

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03869

CERTIFICATE OF DEATH

Reg. Dist. No. 2021

1. PLACE OF DEATH:

County *Kent*City or town *Chesapeake*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *all life*

Hospital, institution, or street address where death occurred:

110 College Ave.

How long in hospital or institution?

3. (a) FULL NAME

Robert Busick

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*M**C**Widowed*

6. (b) Name of husband or wife

John D. Busick

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *July 7 1863*

8. AGE:

Years *82*Months *9*Days *14*

If less than one day hrs. min.

9. Birthplace *Quaker Arch, Kent Co. Md.*

(Town, county, and state)

10. Usual occupation

Farmer - retired

11. Industry or business

Perm. R.R.

FATHER

12. Name

Unknown

MOTHER

13. Birthplace

..

14. Maiden name

Unknown

15. Birthplace

..

16. Informant

*Mrs. Otto L. Johnson*Address *110 College Ave.*

17. Burial

Date thereof *4/25/46*
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory

Chesapeake

Location

Chesapeake - Maryland

18. Funeral director

Wm. V. Williams

Address

*Chesapeake, Maryland*19. Date rec'd by registrar *April 25, 1946*

(Date rec'd by registrar)

Class S. Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Kent*City or town *Chesapeake*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *110 College Ave.*

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 21 1946 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*March 15 1946 to April 21 1946*and that I last saw him alive on *April 15 1946*

Immediate cause of death

*chronic Endo. Per. or arteriolaris
decompression shock*

DURATION

Due to

Hypertension

Due to

Arteriosclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

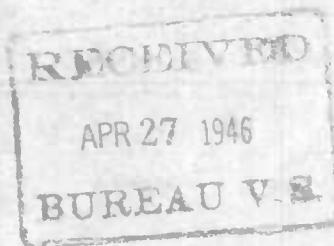
23. SIGNATURE

Albert A. Burgeard

M. D. or other

Address *Post Hall 2nd* Date signed *4/22/46*

Dr. Bengt



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33d

CERTIFICATE OF DEATH

03870

Reg. Dist. No. 204

1. PLACE OF DEATH:

County

Realt -

City or town

Fauquier - Chantelotown RR

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? whole life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas Henry Morris Brumfitt

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white widow

6. (b) Name of husband or wife

Deceased

7. Birth date of

deceased (mo., day, yr.)

January 31 1871

8. AGE:

Years Months Days If less than one day

75

3

17

hrs.

min.

9. Birthplace

15mt Co. Maryland

(Town, county, and state)

10. Usual occupation

Muckout

11. Industry or business

Dairy Brumfitt

MOTHER FATHER

12. Name

Henry D. and

13. Birthplace

Kent Co. Md.

14. Maiden name

Susanna Coleman

15. Birthplace

Kent Co. Md.

16. Informant

Morris Brumfitt

Address

Chantelotown RR 1

17. Burial

Date thereof

4/24/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Wiley Chapel

Location

Rock Hall Maryland

18. Funeral director

Marvin D. Williamson

Address

Chantelotown Maryland

19. Date rec'd by registrar

April 23 1946

(Date rec'd by registrar)

F. O. Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Kent

City or town Fauquier

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1946, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1944 to April 20 1946

and that I last saw him alive on April 20 1946

Immediate cause of death

Cerebral Thrombosis

DURATION

Due to

Cardiac Vasculitis

24 hrs

Due to

Myocarditis

10 years

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

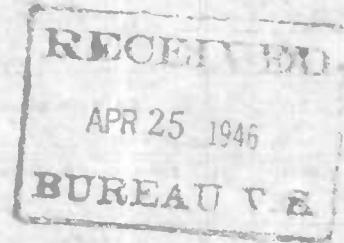
Means of injury

Injured at work?

23. SIGNATURE

Frank J. Smith M. D. or other

Address Chantelotown Date signed April 23/46



Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
of deceased is shown on

2411 N. Charles St., Baltimore

03871

FILM No. 101 APR 11 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 202

VS A15 T
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:

County

City or town

Kent
Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

24 yrs.

Hospital, institution, or street address where death occurred:

Kent and Queen Anne Hospital

How long in hospital or institution?

7 da.

3. (a) FULL NAME

Sarah Catherine Cooper

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife

George N. Cooper

7. Birth date of deceased (mo., day, yr.)

July 25, 1877

6. (c) If alive, give age

70

years

8. AGE:

Years

Months

Days

If less than one day

68 69 8 9

hrs.

min.

9. Birthplace

Chestertown, Kent, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

William A. Wood

(Kent Co.)

MOTHER

13. Birthplace

Maryland

(Kent Co.)

14. Maiden name

15. Birthplace

Sarah R. Miller

Maryland

(Kent Co.)

16. Informant

Hosp. Records

Address

Chestertown, MD

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Apr. 5/46

(month) (day) (year)

Cemetery or crematory

Chest

Location

Chestertown - Maryland

18. Funeral director

Mayn. V. Williams

Address

Chestertown, Maryland

19. April 4

1946

Class S. Barnes

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Kent

City or town

Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Campus Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 2 3 1946 at 4:17 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 27 1946 to April 3 1946

and that I last saw her alive on April 3 1946

Immediate cause of death

Pneumococci meningitis

DURATION

5 days

Due to

Due to

Other conditions Myocarditis, toxic

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. C. Dick M.D.

M. D. or other

Address

Chestertown, MD

Date signed 4-3-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9 (R.D.)

03872

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Kent

Rock Hall, rural

How long in above place of death?

6 m.

Hospital, institution, or street address where death occurred:

George Elburn

How long in hospital or institution?

—

3. (a) FULL NAME

Rebecca Eunice Elburn

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

fem

white

married

6. (b) Name of husband or wife.....

Thomas Elburn

7. Birth date of deceased (mo., day, yr.)

Sept 18 1862

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

83

6

25

hrs.

min.

9. Birthplace.....

Rock Hall, Md.

(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

own home

MOTHER

FATHER

12. Name.....

David Ashley

13. Birthplace

Kent Co., Md.

14. Maiden name.....

Mary Gruch

15. Birthplace

Kent Co.

16. Informant.....

George Elburn

Address

Rock Hall, Md.

17. Buried

Date thereof April 14 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Ashley Cemetery

Location

Rock Hall, Md.

18. Funeral director.....

Edgar L. Lane

Address

Church Hill, Md.

19. 4/13

1946

J. Elwood Bruges

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Rock Hall, rural

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 9 Regis Dr.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 12

1946, at 2¹⁸ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 10 1945 to April 12 1946

and that I last saw h... alive on April 11 1946

Immediate cause of death.....

old age

throm Embol - Myocarditis

Due to..... chronic Arthritis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

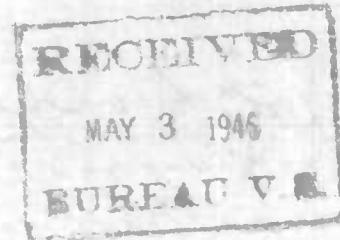
Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Rock Hall, Md. Date signed 4/12/46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

03874

Reg. Dist. No. 202

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Kent

Chesterston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Dora Mildred Hadaway

4. Sex

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Female not married

6. (b) Name of husband or wife

Rebekah Hadaway

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age 55 years

8. AGE:

Years

Months

Days

If less than one day

min.

9. Birthplace

Rock Hall

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

Joseph Dewell

12. Name

Rock Hall

13. Birthplace

Mary Ashley

14. Maiden name

Rock Hall

15. Birthplace

Rebekah Hadaway

16. Informant

Rock Hall

Address

Chesterston MD

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof APRIL 25 1946

(month) (day) (year)

Cemetery or crematory

CHESTER TOWN, MARYLAND

Location

WILLIS WELLS

18. Funeral director

Address CHESTER TOWN, MARYLAND

19. Date rec'd by registrar

April 23, 1946

(Date rec'd by registrar)

Clara S. Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Chesterston MD

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1946 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19, 46, to April 22, 1946,

and that I last saw her alive on April 22, 1946.

Immediate cause of death

Pulmonary tuberculosis 1938

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations Empyema - 2. B.

Date of op. 1939

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank W. Smith

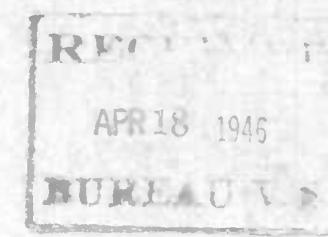
M. D. or other

Address Chesterston Date signed 4/22/46

RECEIVED

APR 25 1946

BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *201*

03876

CERTIFICATE OF DEATH

Reg. Dist. No. *201*

1. PLACE OF DEATH:

County *Kent*City or town *Chestertown*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *21 years*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lewis Francis Henderson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male**White**Married*

6. (b) Name of husband or wife

Margaret Henderson

7. Birth date of deceased (mo. day, yr.)

*July 30 1873*6. (c) If alive, give age *63* years

8. AGE:

Years *72*Months *9*Days *25*If less than one day
hrs. *0* min. *0*

9. Birthplace

Stillpond, Md. Kent Co.

(Town, county, and state)

10. Usual occupation

Farming

11. Industry or business

own

MOTHER

FATHER

12. Name *Lewis Francis Henderson*13. Birthplace *Cecil Co., Md*14. Maiden name *Sarah Eliza Grier*15. Birthplace *Baltimore, Md.*16. Informant *Wm. Henry Henderson*

Address

*Chestertown, Route 2*17. Burial *Burial*

(Burial, cremation, or removal. Which?)

Date thereof *April 27 1946*
(month) (day) (year)Cemetery or crematory *Chestertown*

Location

*Chestertown 2nd*18. Funeral director *B. R. Fellows*

Address

*Stillpond and*19. *April 27 1946*

(Date rec'd by registrar)

J. Melock

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Kent*City or town *Chestertown*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *Route 2*

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 25 1946 at *4:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 3 1946 to *April 25 1946*and that I last saw him alive on *4-22* *1946*

Immediate cause of death

*cerebral hemorrhage**Paralysis*Due to *Lewy - Marg. car. vitis**Hypertension*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

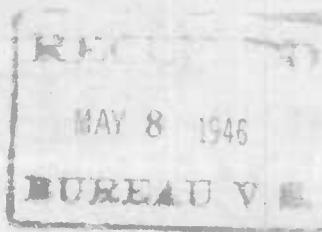
23. SIGNATURE

Albert G. Burgard

M. D. or other

Address

Rock Hall, Md. Date signed *4/15/46*



MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Evidence for change of age of deceased is shown on

STATE OF MARYLAND—CERTIFICATE OF DEATH

FILM No. 10 APR 15 1946

1. PLACE OF DEATH *Hurst* 830

County *Hurst* Registration Dist. No. 202

Village or City *Hurst* St. Ward

Length of residence in city or town where death occurred *19* yrs. *19* mos. *19* ds. How long in U.S. if of foreign birth? *1946* yrs. *19* mos. *19* ds.

2. FULL NAME *George Ryland* ✓

(a) Residence: No. *204* Ward. ✓

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Married</i> (write the word)
3a. If married, widowed, or divorced HUSBAND of <i>Ellevarna Ryland</i> (or) WIFE of <i>Ellevarna Ryland</i>		
6. DATE OF BIRTH (month, day, and year) <i>Nov. 17, 1871</i>	7. AGE <i>74</i> Years <i>7-5</i> Months <i>4</i> Days <i>21</i>	IF LESS than 1 day, <i>0</i> hrs. or <i>0</i> min.
8. Trade, profession, or particular kind of work done, as BAKER, SAWYER, BOOKKEEPER, etc. <i>Formerly</i> <i>Station Master</i>		
9. Industry or business in which work was done, as SAW MILL, BANK, etc. <i>Station Master</i>		
10. Date deceased last worked at this occupation (month and year) <i>Dec 1945</i>		
11. Total time (years) spent in this occupation <i>1</i>		
12. BIRTHPLACE (city or town) <i>Paris, French West Indies</i>		
13. NAME <i>Isaac H. Ryland</i>		
14. BIRTHPLACE (city or town) <i>Ryland, French West Indies</i>		
15. MARRIED NAME <i>Ellevarna Ryland</i>		
16. BIRTHPLACE (city or town) <i>Paris, French West Indies</i>		
17. INFORMANT <i>George Ryland</i> (Address)		
18. BURIAL, CREMATION, OR REMOVAL Place <i>Crompton, Md.</i> Date <i>Apr 10, 1946</i>		
19. UNDERTAKER <i>Thorton Bros.</i> (Address)		
20. FILED <i>April 7, 1946</i> (Address) <i>Clara S. Barnes.</i> (Signature)		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH *April 7, 1946* (Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from *March 17, 1946* to *April 7, 1946*, Date of onset
I last saw him alive on *March 17, 1946*, Date of death
death is said to have occurred on the date stated above, at *1946* m.
The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Heart attack
Heart attack

Other Contributory Causes of importance:

Heart attack

Name of operation *None* Date of (Specify city or town, county and State)

What test confirmed diagnosis? *No* Was there an autopsy? *No*

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? *No* Date of injury (Specify city or town, county and State)

Where did injury occur? *None*

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury (Address)

Nature of injury (Address)

24. Was disease or injury in any way related to occupation of deceased?

If so, specify *Frank Jones* (Address) M. D.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *72d*

03878

CERTIFICATE OF DEATH

Reg. Dist. No. *21021*

1. PLACE OF DEATH:

County.....

Kent

City or town.....

Chestertown, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

life

Hospital, institution, or street address where death occurred:

Johnson town

How long in hospital or institution?.....

3. (a) FULL NAME

Thomas Jefferson Saunders

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*M.**col**widowed*

6. (b) Name of husband or wife.....

Frances Saunders

7. Birth date of deceased (mo. day, yr.)

Sept 11 1867

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Chestertown, Md.

(Town, county, and state)

10. Usual occupation.....

Farming

11. Industry or business

-

MOTHER FATHER

12. Name.....

*Harrison Saunders**Chestertown, Md.*

13. Birthplace

MOTHER

14. Maiden name.....

Elizabeth Coopers

15. Birthplace

*Chestertown**Levi Brown*

16. Informant.....

Johnson town

Address

17. Burial

(Burial, cremation, or removal. Which?)

Data thereof.....

(month) (day) (year)

Cemetery or crematory

Pomona

Location

Quaker Neck

18. Funeral director

Asbury & sons

Address

Chestertown, Md.

19. Date rec'd by registrar

April 19 1946

(Date rec'd by registrar)

Charles Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. *Maryland*

County.....

Kent

City or town.....

Chestertown, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Johnson town

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

*April 18**1946*at *7:00 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*3/31**1946**4/18**1946*and that I last saw him alive on *4/16/46*

Immediate cause of death.....

*chronic Endo - Hypoxic heart disease**Hypertension*

Due to.....

*Paralysis of face;**Enlargement of prostate**Cystitis*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

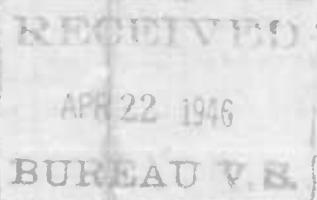
Albert H. Burgard

M. D. or other

Address.....

Rock Hall, Md.

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1568

CERTIFICATE OF DEATH

113879 201
Reg. Dist. No.

1. PLACE OF DEATH:

County Kent

City or town Bostertown and

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

William Henry Smith

4. Sex Male 5. Color or race Mulatto 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Isaac Fields Smith

7. Birth date of deceased (mo., day, yr.) Oct 19 1865

8. AGE: Years 80 Months 5 Days 15 It less than one day hrs. min.

9. Birthplace Cecil County, Md. (Town, county, and state)

10. Usual occupation Janitor

11. Industry or business School

12. Name Samuel Smith

13. Birthplace Maryland

14. Maiden name Luricia Cosden

15. Birthplace Maryland

16. Informant Mrs. Edwards Smith

Address Kennedyville, Md.

17. Burial Date thereof Oct. 7 1946
(Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory Chester

Location Chester County, Md.

18. Funeral director B. R. Fellows

Address Still Pond, Md.

19. Oct 5 1946 J. W. Clark
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Kent

City or town

Bostertown and

Street No.

(If outside city or town limits, write RURAL and give nearest town)

2. (a) If veteran, name war: _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1946, at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1 1946 to April 3 1946

and that I last saw him alive on April 3 1946

Immediate cause of death Hypostatic pneumonia

Due to Neuroasthenia, Myasthenia

Due to Senility

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jones Edwin Dederman M.D.

M. D. or other

Address Box 19-Bostertown Md. Date signed 4-4-46

RE

MAY 8 1946

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Md.*

CERTIFICATE OF DEATH

4/19/46 13880
Reg. Dist. No. 2102

1. PLACE OF DEATH:

County *Kent*City or town *Chestertown*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

*Kent and Queen Anne Hospital*How long in hospital or institution? *48 days*

3. (a) FULL NAME

Richard Halstead Warrin

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife *Marie Louise Rosset*

Decocembrent Warrin

6. (c) If alive, give age

years

7. Birth date of

deceased (mo., day, yr.) *March 20, 1879*

8. AGE:

Years *67* Months *0* Days *17* If less than one day hrs. min.

9. Birthplace

Chicago Illinois
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER 12. Name *Samuel Lord Warrin*13. Birthplace *New Town, Long Island, N.Y.*MOTHER 14. Maiden name *Sarah Helen Hathaway*15. Birthplace *New Town, Long Island, N.Y.*16. Informant *Hospital Records*Address *Chestertown, Md.*17. Cremation Date thereof *4/8/46*
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory *Green Mount*Location *Baltimore, Md.*18. Funeral director *Wm. L. Williams*Address *Chestertown, Maryland*19. April 8 Date rec'd by registrar *1946*

Class L. Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Kent*City or town *Chestertown*
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 26* 1946 at *8:25* P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Feb. 18 1946 to *April 6* 1946and that I last saw him alive on *April 26* 1946

Immediate cause of death

*Cardiac decompensation**Chronic myocarditis**Hypertrophic fibrillation*

DURATION

*48 days**6 mos.**6 mos.*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Al Dick

M. D. or other

Address *Chestertown, Md.* Date signed *April 6 1946*

RECEIVED

APR 10 1945

BUREAU